CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION
BOARD OF DENTISTRY AND DENTAL HYGIENE

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV

APPLICATION FOR DENTAL RESIDENT LIMITED LICENSURE
INSTRUCTION SHEET

What is Dental Resident Limited Licensure?

This application is for dentists who will be starting a residency program in Delaware. Under a Dental Resident Limited License, you are allowed to practice dentistry:

- ***only*** in the sponsoring hospital or institution named on the license
- ***only*** under the direction of a licensed dentist employed by the sponsoring hospital or institution.

Dental Resident Limited Licenses are valid for one year. If you do not complete your residency program in the year, you may apply to continue your limited licensure.

Requirements for *All* Applicants

As the applicant, it is ***your*** responsibility – *not the responsibility of the institution or residency program* – to arrange for the Board to receive the documents listed below.

☐ Submit completed, signed and notarized *Application for Dental Resident Limited Licensure*.

☐ Enclose the processing fee by check or money order made payable to the "State of Delaware."

☐ Arrange for the Board office to receive an official transcript of your undergraduate education, sent *directly* from the college/university (not the residency program) to the Board office.

☐ Arrange for the Board office to receive an official transcript from your dental college or university, sent *directly* from the school to the Board office. The transcript must show your degree and date of graduation

- The dental college/university must be accredited by the Commission on Dental Accreditation of the American Dental Association (CODA).
- If a final transcript is not available by the program start date, submit a letter from your school's dean attesting to your good academic standing.

☐ Submit a copy of your letter of acceptance into a dental residency program from the sponsoring institution. The program must be a CODA-accredited general practice residency or a CODA-approved specialty residency. (Rules and Regulations governing specialty residencies are currently under development.)

☐ Enclose a copy of your current cardiopulmonary resuscitation (CPR) certification card.

☐ Arrange for the Board office to receive license verification letters from *each* jurisdiction (state, U.S. territory or District of Columbia) where you are now, or have ever been, licensed, sent directly from the jurisdiction to the Board office.

☐ Complete the *Criminal History Record Check Authorization* form to request state and federal criminal background checks. Follow the instructions on the authorization form to arrange to be fingerprinted.

☐ If you have never been issued a U.S. Social Security Number (SSN), submit a *Request for Exemption from Social Security Number Requirement*.

- The Privacy Act of 1974, Section 7, requires the following information to be given to all applicants: Applicants for any Delaware professional or occupational license, permit, registration or certificate (other than Gaming permits) are required to provide a U.S. SSN (29 Del. C. §8735(m)). The Division of Professional Regulation uses the SSN primarily to verify identity and safeguard personal information. It may also be used to enforce child support obligation (13 Del. C. §2216) and for other lawful purposes.

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IDENTIFYING AND CONTACT INFORMATION

1. Name :_____ _____ _____ _____
   Last/Family Name | First | Middle | Maiden

2. Other Name(s) Used: _____ _____ _____

3. Have you ever sought or been granted a dental license under another name? Yes ☐ No ☐ If yes, enter name and state where you used the name: _____

4. Date of Birth (month/day/year): _____ Gender: Male ☐ Female ☐

5. Have you been issued a U.S. Social Security Number? Yes ☐ No ☐
   - If yes, enter your SSN:_____
   - If no, you must file a *Request for Exemption from Social Security Number Requirement*.

6. Mailing Address:_____

   _____ _____ _____
   City | State | Zip

7. Phone: _____ _____ Email: _____
   Daytime | Home

RESIDENCY PROGRAM

8. Enter the following information about your residency program: Start Date: _____

   Name of Sponsoring Institution: _____

   Mailing Address: _____

   _____ _____ _____
   City | State | Zip

   Submit a copy of your letter of acceptance into the dental internship program from your sponsoring institution. Also, enclose a copy of your current cardiopulmonary resuscitation (CPR) certification card.

EDUCATION

9. Enter the following information about your pre-professional education:

   University/College: _____ Major: _____
   City: _____ State: _____ Degree: _____
   Dates Attended: From: _____ To: _____ Graduation Date: _____
   month/day/year | month/day/year | month/day/year

   Arrange for the Board office to receive an official transcript of your undergraduate education, sent directly from the college/university (not the residency program) to the Board office.

10. Enter the following information about your Dental education:

Dental School Name: _____
City: _____ State: _____ Degree: _____
Dates Attended: From: _____ To: _____ Graduation Date: _____
month/day/year month/day/year month/day/year

Arrange for the Board office to receive an official transcript, sent *directly* from your dental school (<u>not</u> the residency program) to the Board office. If a final transcript is not available by the program start date, submit a letter from your school's dean attesting to your good academic standing.

LICENSURE & PRACTICE HISTORY

11. Enter the following information about your National Board Examinations:

Year Taken:_____ Part I Score:_____ Part II Score:_____

12. Have you ever been denied a license? Yes ☐ No ☐ If yes, enter: Year Denied: _____ State: _____ Submit a letter explaining fully.

13. Are you (*or have you ever been*) licensed in any other jurisdiction? Yes ☐ No ☐ If yes, enter the following information about *each* license:

JURISDICTION	LICENSE NUMBER	ISSUE DATE	EXPIRATION DATE	STATUS (e.g.,active)

Arrange for *each* jurisdiction listed to send a verification of licensure *directly* to the Board office.

DISCLOSURES

14. Have you engaged in the illegal use of controlled dangerous substances within that past two years? Yes ☐ No ☐ If yes, continue to Question 15. If no, skip to Question 16.

15. Are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not illegally using controlled substances? Yes ☐ No ☐ If yes, submit a letter explaining fully.

16. Have you ever been denied a DEA (Narcotic) registration number? Yes ☐ No ☐ Current DEA #_____ If yes, submit a letter explaining fully.

17. Have you ever been convicted of or entered a plea of guilty or *nolo contendere* (no contest) to any felony, misdemeanor or other criminal offense, including any offense for which you have received a pardon, in any jurisdiction? Yes ☐ No ☐

If yes, submit a letter explaining fully and arrange for the Board office to receive state and federal criminal background checks using the *Instructions for Requesting a Criminal Background Check*.

18. Have you ever had your professional license subjected to disciplinary action (including but not limited to consent agreements, fines, probation, suspension or revocation)? Yes ☐ No ☐ If yes, submit a letter explaining fully. Include an official Board order or other documents.

19. Have you had any malpractice actions brought against you in the past five years? Yes ☐ No ☐ If yes, enclose a list on a separate sheet of paper. Include dates, disposition and amount of awards or settlements, if any.

20. Are any disciplinary or ethical complaints currently pending against you? Yes ☐ No ☐ If yes, submit a letter fully explaining. Include copies of all official documents or Board orders.

21. Are you physically or mentally incapable of engaging in the practice of dentistry according to generally accepted standards? Yes ☐ No ☐ **If yes, continue with Question 22. If no, skip to the DUTY TO REPORT section.**

22. Do you agree to submit to an examination to determine such capability as the Board may deem necessary?
Yes ☐ No ☐

DUTY TO REPORT

23. To obtain a license in Delaware, you must certify that you understand that you have a **mandatory** obligation to self report any of the following within 30 days:
    - Any arrest or the bringing of an indictment or information charging you with a crime substantially related to the practice of dentistry and dental hygiene as defined in Section 11.0 of the Board's Rules and Regulations.
    - Any conviction, including any verdict of guilty or plea of guilty or no contest, of any crime substantially related to the practice of dentistry and dental hygiene as defined in the Section 11.0 of the Board's Rules and Regulations.

    I certify that I have read and understand all provisions in the Delaware Dental Practice Act, including 24 *Del. C.* §1131 and the Rules and Regulations listed above, and that I understand my *duty to self report*. Yes ☐ No ☐

24. To obtain a license in Delaware, you must certify that you understand that you have a ***mandatory*** obligation to make an immediate oral report to the to the Department of Services for Children, Youth and Their Families if you know of, or you suspect, child abuse or neglect under Chapter 9 of Title 16 and to follow up with any requested written reports.

    I certify that I have read and understand 16 *Del. C.* §903 and that I understand my *duty to report*. Yes ☐ No ☐

25. You have a ***mandatory*** obligation to file a written report with the Board of Medical Licensure and Discipline within 30 days if you have any reason to believe that a medical practitioner is (or may be) guilty of unprofessional conduct as defined in 24 *Del. C.* §1731 OR that he/she is (or may be):
    - medically incompetent
    - mentally or physically unable to engage safely in the practice of medicine
    - is excessively using or abusing drugs including alcohol.

    I certify that I have read and understand the provisions of 24 *Del. C.* §1730, 24 *Del. C.* §1731 and 24 *Del. C.* §1731A and that I understand my *duty to report*. Yes ☐ No ☐

    To assure consideration of your license application, the Board office must receive all of these items:
    - **Completed, signed and notarized application form**
    - **Fee payment**
    - **All required supporting documentation.**

    Applications that are not complete within six months of filing may be considered abandoned and discarded.

    When your application is complete, please allow 4-6 weeks to receive your license.

AFFIDAVIT

I hereby apply to be considered for licensing as a Dental Resident by the Board of Dentistry and Dental Hygiene under the standards, qualifications and procedures established under Title 24, Chapter 11, of the *Delaware Code*. I have read the State statute governing dental residents in Delaware. I have also received and read the Board's Rules and Regulations regarding the practice of Dentistry and Dental Hygiene in Delaware. I understand that the Board may require evidence additional to the material herein, including a written examination, and transcripts of academic training.

I hereby swear or affirm that the information contained in this application is correct and I understand that any intentionally fraudulent information will be reported to the Attorney General.

APPLICANT SIGNATURE: _____ Date: _____

County of_____State of _____

Sworn or affirmed before me a Notary Public this_____day of _____, 2_____.

Notary Signature: _____

SEAL

My commission expires on_____

APPLICATIONS THAT ARE UNSIGNED, NOT NOTARIZED, INCOMPLETE OR SUBMITTED WITHOUT THE REQUIRED FEE WILL BE REJECTED.

Instructions for Requesting a Criminal Background Check

Both state and federal criminal background checks are required.

Locations

Kent County – Primary Facility
State Bureau of Identification
Blue Hen Mall & Corporate Center
655 Bay Rd. Suite 1B
Dover, DE 19901
Walk-ins accepted: Mon 9 am – 7 pm, Tue - Fri 9 am – 3 pm
Customer Service: (302) 739-2134

New Castle County - Satellite Facility
State Police Troop Two
100 LaGrange Ave
Newark, DE 19702
(Between Rts. 72 and 896 on Rt. 40)
By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Sussex County – Satellite Facility
Delaware State Police Troop Four
South DuPont Hwy & Shortley Rd.
Georgetown DE 19947
(Across from DelDOT & the State Service Ctr.)
By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Applicants Residing in Delaware

1. If you are using the New Castle or Sussex Counties locations, call **(800) 464-HELP (4357)** to schedule an appointment. No appointments are needed at the Kent County location.

2. Take the completed *Authorization for Release of Information* form to one of the offices listed above with the fee of $69.00, to cover both the State and Federal criminal checks. Money orders and credit cards other than American Express are accepted at all locations. New Castle and Kent Counties accept cash; Sussex County does not accept cash. *Personal checks are not accepted in any county.* As fees are subject to change, contact the agency where you plan to submit your forms for current fees.

Out-of-State Applicants

1. You can be fingerprinted by your local police agency. All types of fingerprint cards are accepted. If your local police agency cannot provide a fingerprint card, call **(302) 739-2134** to request a fingerprint card.

2. Your *Authorization for Release of Information* form and fingerprint card must be complete. If identifying information is missing (such as name, date of birth, race, sex, etc.), your form will be returned. Send the *Authorization* form, fingerprint card, and certified check or money order (*personal checks are not accepted*) for $69.00 made payable to "Delaware State Police" to:

Delaware State Police
State Bureau of Identification (SBI)
PO Box 430
Dover, DE 19903-0430

⇨***ALLOW FOUR WEEKS FOR RECEIPT OF RESULTS.***

DO NOT SEND THE FORM OR FEE TO THE BOARD OFFICE

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CRIMINAL HISTORY RECORD CHECK FOR PROFESSIONAL LICENSURE APPLICANTS

PLEASE PRINT OR TYPE ALL INFORMATION IN BLACK INK.

CHECK TYPE OF LICENSURE FOR WHICH APPLYING:

- ☐ Adult Entertainment
- ☐ Deadly Weapons Dealer
- ☐ Dental
- ☐ Medical
- ☐ Nursing
- ☐ Nursing Home Administrator
- ☐ Pharmacy
- ☐ Texas Hold'em Dealer
- ☐ Other _____

ENTER FULL CURRENT NAME:

_____ _____ _____ _____
Last Name | First Name | Middle Initial | Suffix (e.g., Jr., Sr.)

ENTER ALL OTHER NAMES USED IN THE PAST (including, but not limited to, maiden name, former married names, alternative spellings):

1. _____
2. _____
3. _____
4. _____

AUTHORIZATION TO RELEASE INFORMATION

As an applicant, I authorize release of any and all information that you have concerning me, including **CRIMINAL HISTORY RECORD INFORMATION** and other information of a confidential or privileged nature. I hereby release you, your organization, the State of Delaware and others from any liability or damage which may result from furnishing this information:

SIGNATURE OF PERSON PRINTED: _____ **Date:** _____

Phone: Home _____ Work: _____

MAIL THE RESULTS OF MY CRIMINAL HISTORY REQUEST TO:

Division of Professional Regulations
861 Silver Lake Boulevard, Suite 203
Dover DE 19904
SLC D420A

USE OF CRIMINAL HISTORY RECORD INFORMATION IS RESTRICTED BY LAW AND SHALL BE LIMITED TO THE PURPOSE FOR WHICH IT WAS GIVEN. MISUSE CONSTITUTES A CRIMINAL VIOLATION.